Psoriasis & Eczema
Centers of Kentucky

PATIENT REFERRAL FORM

901 South Highway 27, Somerset, KY 42501 | Phone: 606-648-RASH (7274) | Fax: 606-485-3255 | refer@psoky.com

Fax completed form to 606-485-3255. Attach relevant notes, labs, insurance card, or photos when available. For emergencies, call 9-1-1.

1. PATIENT INFORMATION

Patient full name _____ **Date of birth** _____ **Gender** ☐ M ☐ F ☐ Other

Phone number _____ **Email** _____

Street address _____ **City / State / ZIP** _____

2. REASON FOR REFERRAL

Diagnosis / symptoms / reason for referral

Urgency ☐ Routine ☐ Soon / worsening ☐ Urgent - please call **Patient age** ☐ 18+

Current or prior treatments / medications, if known

3. INSURANCE INFORMATION

Primary insurance company _____ **Policy / Member ID** _____

Group number _____ **Is patient policy holder?** ☐ Yes ☐ No **Policy holder name, if different** _____

4. REFERRING PROVIDER / OFFICE INFORMATION

Referring provider name _____ **Practice / facility** _____

Office phone _____ **Office fax** _____ **NPI, if available** _____ **Contact person** _____

Additional comments for PsOky staff